PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: September 24, 2015

Auditor Information			
Auditor name: Jeff Kovar			
Address: P.O. Box 552 Richmond, TX 77406			
Email: jeff@preaauditing.com			
Telephone number: 832-833-9126			
Date of facility visit: September 10, 2015			
Facility Information			
Facility name: Threshold, Inc.			
Facility physical address: 1702 St. Paul Street Baltimore, MD 21202			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 410-727-0100			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☒ Other	
Name of facility's Chief Executive Officer: Carlton C. Gordon			
Number of staff assigned to the facility in the last 12 months: 13			
Designed facility capacity: 32			
Current population of facility: 31			
Facility security levels/inmate custody levels: Pre-release			
Age range of the population: 18-64			
Name of PREA Compliance Manager: Victor Caldarola		**Title:** Contract Compliance Manager for Transitional Services	
Email address: vcaldarola@dpscs.state.md.us		**Telephone number:** 410-585-3531	
Agency Information			
Name of agency: Division of Parole & Probation			
Governing authority or parent agency: *(if applicable)* Maryland Department of Public Safety and Correctional Services			
Physical address: 6776 Reisterstown Rd., Suite 212A, Baltimore, MD 21215			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 410-585-3500			
Agency Chief Executive Officer			
Name: Judith Sachwald		**Title:** Director, DPP	
Email address: jsachwald@dpscs.state.md.us		**Telephone number:** 410-585-3566	
Agency-Wide PREA Coordinator			
Name: Rhea Harris		**Title:** Assistant Secretary, Programs and Services	
Email address: rharris2@dpscs.state.md.us		**Telephone number:** 410-339-5055	

AUDIT FINDINGS

NARRATIVE

A Prison Rape Elimination Act Audit of Threshold, Inc. was conducted on September 10, 2015. The purpose of the audit was to determine compliance with the Prison Rape Elimination Act standards which became effective August 20, 2012.

An entrance meeting was held the morning of the onsite audit with the following persons: Victor J. Caldarola, Ph.D.- Contract Compliance Manager for Transitional Services, DPSCS, Curtis Barnett- Assistant Director, Threshold, Nicole Halsey- Administrative Assistant, Threshold.

The auditor wishes to extend his appreciation to the facility's Chief Executive Officer- Carlton C. Gordon as well as PREA Compliance Manager- Victor Caldarola, and their staff for the professionalism they demonstrated throughout the audit and their willingness to comply with all requests and recommendations made by the auditor.

The auditor would also like to recognize PREA Coordinator Rhea Harris for her hard work and dedication to ensure the facility is compliant with all PREA standards.

After the entrance meeting, the auditor was given a tour of all areas of the facility, including: all housing areas, laundry, kitchen, dining room, boiler room, GED classroom, additional storage area, intake area, and miscellaneous offices. During the tour, informal interviews were conducted with inmates and staff throughout the facility.

A total of 20 staff were interviewed with at least one staff member interviewed from each interview category, with the exception of the interviews related to non-medical staff involved in cross-gender searches and staff who supervise inmates in segregated housing (these interview types were not applicable to the facility). Medical/mental health services are conducted at Metropolitan Transition Center (MTC). One medical and one mental health staff from MTC were interviewed.

Staff were interviewed on all three shifts.

A total of 11inmates were interviewed. Only random inmate interviews were conducted. There were not any inmates housed, meeting the other interview types.

Telephone interviews were conducted with the Agency Head, Agency Contract Administrator, SAFE/SANE, and contractor staff.

The morning count was 32, and the afternoon count was 32.

Throughout the pre-audit and onsite audit, open and positive communication was established between the auditor and facility staff. During this time, the auditor discussed his concerns with PREA Compliance Manager Victor Caldarola and Special Assistant David Wolinski. Through a coordinated effort by these key staff members as well as other staff, all issues were addressed and corrected to the satisfaction of the auditor prior to the completion of the Final Report.

When the audit was completed, the auditor conducted an exit briefing on September 10, 2015. The auditor gave an overview of the audit and thanked the staff for all their hard work and commitment to the Prison Rape Elimination Act.

DESCRIPTION OF FACILITY CHARACTERISTICS

Threshold, Inc. was founded in 1969 as a halfway house for offenders. The facility was located at the old Madison Avenue YWCA. In 1972, Threshold, Inc became an all-male program, and moved to its present location at 1702 St. Paul Street. The facility is a three-story masonry structure build in 1929 and is approximately 3400 sq. ft., with a basement. The main entrance is on the first floor, where the front door is controlled by a buzzer release operated by the house manager. The house manager's station/operation area is directly adjacent to the foyer and hallway. The dining/multi-purpose room, staff lavatories and kitchen are the adjoining rooms on the first floor. There is a small storage closet in the corridor. All levels of the facility have a fully operational fire sprinkler system.

The residents are housed on the second and third levels of the building at 1702 St. Paul in six separate bedrooms. The bedrooms are set up as dormitories and contain four to eight unattached beds, mostly bunked, with a variety of lockers, chests, tables and other assorted furniture. Closets are in most of the dormitories. A small lavatory with a porcelain toilet, wash basin and shower is located on each floor. Overhead lights are in the hallways and the living quarters have ceiling lights and fans. The middle bedroom on each floor has an alarmed window with access to a fire escape.

The administrative offices are in the basement. A dry food storage room, a laundry room, a boiler room and miscellaneous storage space are also in this area. One stairway connects all levels of the building with fire doors separating each of the floors. The rear of the building contains a small yard bordering an alley.

The education building, which was constructed in 1999, is adjacent to the rear yard. It is a two-story brick structure with a conference area, a small compact kitchen, a storage closet and a furnace room on the first floor. The second floor is used for storage and has a non-working bathroom.

Threshold has nine surveillance cameras. The cameras cover the front entrance, operations office, fire escape, dining rooms, backyard and the first and second floors of the Education building. There are no surveillance cameras in the stair wells, second and third floor hallways, the dormitories, or basement laundry room.

SUMMARY OF AUDIT FINDINGS

After reviewing all information provided during the pre-audit and onsite audit, including, staff and inmate interviews, the auditor has determined the following:

Number of standards exceeded: 2

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency has three separate policies mandating a zero tolerance policy towards sexual abuse and sexual harassment (COS.200.0004 Inmate on Inmate Sexual Conduct Prohibited, DPSCS.020.0026 PREA-Federal Standards Compliance, and DPSCS.050.0030 Sexual Misconduct Prohibited). UD200 Zero Tolerance is the private facility's policy on zero tolerance of sexual abuse and sexual harassment. These policies outline the Agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Included in these policies are both the inmates' and staffs' responsibilities to ensure an atmosphere free of misconduct. These policies include definitions of prohibited behaviors regarding sexual abuse and sexual harassment for both inmates and staff. Sanctions for prohibited behaviors are listed in the policy. A zero tolerance policy for sexual misconduct was also discovered in four separate contractor policies.

DPSCS.020.0026 Prison Rape Elimination Act- Federal Standards Compliance lists detailed responsibilities for the PREA Coordinator, PREA Compliance Manager, and PREA Committee. The Agency's strategies and responses to reduce and prevent sexual abuse and sexual harassment of inmates are outlined in policy.

The Agency appointed an upper level, agency-wide PREA Coordinator who is the Assistant Secretary/Chief of Staff and reports directly to the DPSCS, Chief of Staff. The PREA Coordinator oversees 3 Regional Managers and 17 PREA Compliance Managers. The team communicates through emails, phone calls, and site visits. In addition, the PREA Coordinator has 9 Department of Justice Certified PREA Auditors which help monitor PREA compliance throughout the state of Maryland. The auditor was advised this is an example of the Agency's commitment to the Prison Rape Elimination Act.

The facility has a designated PREA Compliance Manager who holds the title of Contract Compliance Manager for Transitional Services.

Interviews with staff reflect a system-wide knowledge regarding a zero tolerance approach to sexual abuse and sexual harassment. During the onsite audit, the auditor discovered the PREA Coordinator has several roles and responsibilities in addition to serving as the PREA Coordinator.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The Agency has entered into one contract for the confinement of inmates on or after August 20, 2012. This contract is with Threshold, Inc. (dated July 1, 2013) and is for the housing and rehabilitation of inmates in a community confinement facility. The

contract requires the contractor to fully comply with the standards set forth in the Prison Rape Elimination Act of 2003, and with all applicable regulations issued by the United States Department of Justice.

There is a DOJ certified PREA auditor that works for the Agency who is responsible for monitoring all inmate housing contracts. This individual monitors these facilities and ensures they are PREA compliant. The Agency Contract Administrator works closely with the contractor to ensure its facilities comply with the PREA standards.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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DPSCS.115.0001 Staffing Analysis and Overtime Management establishes a staffing plan for the facilities to comply with on a regular basis and states that all facility staffing plans are reviewed annually. DOC.100.0029 Collabsible Posts provides the Director with a management tool to close posts when needed to reduce overtime. Posts are classified by their Operational Security Level with lower security levels closed first.

Since August 20, 2012, the average daily number of residents was 30.

Since August 20, 2012, the average daily number of residents on which the staffing plan was predicated was 30.

There have not been any deviations from the staffing plan noted during the pre-audit.

Through interviews with management staff, it was determined the facility has developed and follows a staffing plan. Adequate levels of staff and video monitorning is considered as a part of the staffing plan. The staffing plan is documented in the employee work schedule. The staffing plan is evaluated every month. The management staff checks for compliance with the staffing plan by reviewing the daily log books. The auditor was advised there have never been any issues of non-compliance with the staffing plan. If the facility had an issue where a staff member called in sick, one of the duty officers would be called in to work.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

IID.100.0008 Strip and Body Cavity Searches prohibit cross-gender strip and body cavity searches, except in exigent

circumstances. This policy also requires that all strip and body cavity searches are documented.

Facility Directive UD215 states only male staff members will conduct a strip search of male residents. There must be a minimum of two male staff members conducting the search. When conducting a strip search, male staff shall ensure that, to the extent possible, the search is conducted in a professional manner to ensure privacy to maintain a level of personal dignity for the individual being searched.

There were no cross-gender strip or cross-gender visual body cavity searches of residents reported at this facility.

OPS.100.0047 Inmate Personal Searches states a frisk search of a female resident shall be conducted by a female correctional officer. Threshold, Inc. is an all male facility; therefore, there were no pat-down searches of female residents that were conducted by male staff reported at this facility.

The facility provides training specific to Inmate Processing and Inmate Searches. These lesson plans cover the proper search techniques for cross-gender pat-down searches.

OSPS.050.0030 Sexual Misconduct outlines the facility's policies and procedures for cross-gender viewing. Cross-gender viewing, defined as an employee who observes the breasts, buttocks, or genitalia of a resident of the opposite sex while the resident is showering, performing bodily functions, changing clothing, or any similar activity, may be considered sexual misconduct, if performed without warning by non-medical staff at times other than incidental to a routine cell check, supervisory rounds to prevent sexual abuse and harassment, or exigent circumstances.

Facility Directive UD215 staff are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

There have not been any searches conducted of transgender/intersex residents for the sole purpose of determining the resident's genital status.

The auditor was advised 100% of staff have been trained on conducting cross-gender pat-down searches and searches of transgender and intersex inmates in a professional and respectful manner, consistent with security needs.

During interviews with staff and residents, it was determined that announcements are typically made any time a female staff member enters the housing area. Some staff were unclear that an announcement was required for security staff. This was discussed with the management team during the close out meeting. The auditor requested the management team provide refresher training to all staff in regards to making an announcement whenever female staff enter the housing area. The auditor was provided with documentation of refresher training prior to the completion of the Final Report.

During interviews with staff, it was determined staff were unfamiliar with the Agency policy pertaining to searches of transgender residents. The auditor was provided with documentation of refresher training prior to the completion of the Final Report.

There were no Transgender/Intersex residents housed at this facility at the time of the audit. Staff interviews indicate Transgender/Intersex residents are typically housed at another facility.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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DCD.200.0001 Inmate Rights and DPDP.200.0002 Disability Accomodation establishes procedures for disabled and Limited English proficient residents and affords them equal opportunity to participate in or benefit from all aspects of the Agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. DCD.200.0001 Inmate Rights also mandates that special assistance will be provided to those residents with language or reading problems.

The Agency has a lesson plan for special management issues which goes over the appropriate methods of handling residents with medical and physical disabilities.

The Agency has documented contracts with language interpreter lines and documented procedures on how to use this service. The Agency has a contract with AdAstra for translation service. During the onsite audit, the auditor was advised there were not any disabled or limited English speaking inmates at the facility; however, the auditor was provided with account information for the AdAstra translation service.

The Agency has PREA Informational Handouts written in the Spanish language that are given to Spanish speaking inmates.

COS.200.0004 Inmate Sexual Conduct states the head of a unit, or a designee, responsible for the custody and security of an resident, shall ensure that, except under limited circumstances where a delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first responder duties, or the investigation are not used to communicate information required under this directive to other residents.

OSPS.050.0030 Sexual Misconduct states resident interpreters, resident readers, or other types of resident assistants are not used to communicate information required under this directive to other resident, except under limited circumstances where a delay in obtaining an effective non-resident interpreter would compromise the resident's safety, the performance of the first responder duties, or the investigation of an resident's allegation.

In the past 12 months, there have not been any instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of the first-response duties under 115.264, or the investigation of the resident's allegations.

Interviews with staff reflect the Agency makes reasonable accommodations for residents who are disabled and limited English proficient, to ensure compliance with PREA standards. Staff interviews indicate resident interpreters are not permitted, except in limited circumstances.

Standard 115.217 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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AMD.050.0041 requires criminal background checks be conducted on all employees, including contractors. 100% of all staff hired who may have contact with residents have had criminal background record checks.

DSPCS Interviewing/Hiring Process requires all applicants who answered "yes" to any of the PREA related questions be referred to the Attorney General's Office for review and recommendation. This policy also requires Human Resources to contact all prior institutional employers and review their personnel files.

The facility conducted criminal background record checks on all staff in 100% of all contracts which involves personnel who might have contact with residents.

Hiring guidelines prohibit the hiring of someone who was convicted of a crime punishable by imprisonment of a term of one year or more. These guidelines prohibit the hiring of any convicted sexual offender.

The Agency Personal Interview Form asks the applicant several questions about any prior sexual abuse history. This form has an acknowledgement for the applicant to sign, documenting the information provided was accurate and that any misrepresentation or falsification are grounds for immediate termination.

Under COMAR 12.15.01.1, all employees are placed in a system that provides automatic updates to criminal history.

COMAR 12.15.01.19 State Rap Back Program mandates annual criminal background checks to be conducted on all employees (exceeding the requirement under PREA Standards, which require backgrounds be ran every five years). All employees are fingerprinted when they are hired. This information is entered into a database. If an employee were ever arrested, an alert would instantaneously be sent to the Agency for their review and investigation.

The agency conducts polygraph examinations on potential applicants and asks specific questions related to PREA.

During the onsite audit, the auditor reviewed a sample of five contractor and five facility staff personnel files. The auditor discovered documentation showing backgrounds were conducted on all ten staff sampled.

Interviews with the facility Human Resources staff indicate background investigations are conducted by the Agency Human Resources Department on all facility staff. The auditor was advised contractor background investigations are conducted by the facility Human Resources staff. In addition, both facility staff and contractor staff are asked specific questions related to PREA as part of the hiring proces. The auditor was provided with a list of the interview questions.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The Agency/facility has not acquired any new facilities or made any substantial expansions or modifications of existing facilities since August 20, 2012.

The Agency/facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012.

Threshold has 9 surveillance cameras. The most recent cameras were installed in August of 2014. The facility has applied for a grant for funding for an additional 6 cameras. Video is retained for approximately 1 week.

During the onsite tour, the auditor discovered a potential blind spot in the boiler room. The boiler room was downstairs in an area which is normally off-limits to inmates. The boiler room did not not have a lock on the door, which enabled access to the residents at the facility. This was discussed with the management staff, and prior to the completion of the onsite audit, this door was secured with a locking device.

Interviews with the administrative staff indicate camera placement is strongly considered during facility expantions as well as during annual staffing reviews.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The Agency/facility is responsible for conducting administrative and criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). IID.220.0002 Evidence Collection outlines the Agency's uniform evidence protocol.

The standard care provided to sexual assault victims is regulated by the Code of Maryland (COMAR).

Hospitals in the state are certified as having SAFE programs and sexual assault victims (including those from the Agency's facilities) are taken to those facilities for examination and treatment. Agreements are not needed.

The facility offers all residents who experience sexual abuse access to forensic medical examinations which are conducted by SANEs or SAFEs. There are 25 hospitals across the State of Maryland that offer these services. The Agency utilizes four of these hospitals for such services. The State of Maryland is split up into a Northern Zone with two hospitals providing coverage for that area, a Central Zone with one hospital providing coverage for that area, and a Southern Zone with one hospital providing coverage for that area. When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations.

There have not been any forensic medical examinations conducted during the past 12 months.

OSPS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct mandate that forensic medical examinations are offered without financial cost to the victim.

IID.110.0011 Investigating Sex Related Offenses and COS.200.0004 Inmate Sexual Conduct mandates that if requested by the victim, the facility attempt to make a qualified victim advocate available to the victim who will accompany, for the purpose of support, the victim through the forensic examination and investigation interviews. COS.200.0004 Inmate Sexual Conduct states a Department employee who is not otherwise involved in the incident and has received education and training concerning sexual assault and forensic examination issues and who has been appropriately screened and determined competent to serve in the role, may serve as a victim advocate.

Interviews confirmed that SAFEs/SANEs are readily available at hospitals throughout Maryland. There are SAFEs/SANEs on call 24 hours a day, 7 days a week. A victim advocate is provided at the hospital for all victims of sexual abuse. In addition, the Agency currently has an MOU pending with Maryland Coalition Against Sexual Assault (MCASA) to provide inmates at the facility with a victim advocate. The auditor was advised grant funds are available and MCASA has a staff member currently working on a statewide program. The auditor was advised the hospitals provide a victim advocate for the inmate at the hospital. A qualified Agency staff member would serve the role as the victim advocate when needed.

Interviews with staff indicate they were knowledgeable regarding the collection and preservation of evidence.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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COS.200.0004 Inmate Sexual Conduct, OSPS.050.0030 Sexual Misconduct, DPSCS.020.0026 PREA Compliance, and IID.110.0011 Investigating Sex Related Offenses ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Facility Policy UD210 states the facility shall ensure that all administrative and criminal investigations are completed for all allegations of sexual abuse and sexual harassment. Residents may be transferred to MRDCC for protective custody while the investigation is ongoing. The facility shall document all such referrals. It is the policy of this facility to coordinate allegations of sexual abuse or sexual harassment with the PREA Compliance Manager and facilitate administrative or criminal investigations as appropriate. This policy shall be published in the inmate handbook, the Summary of Services, and in general publications.

During the last 12 months, there has been one allegation of sexual abuse or sexual harassment received. Through interviews it was determined the inmates involved were transferred to more secure facility pending the outcome of the investigation. Investigators quickly determined this was a false allegation and that the inmate making the allegation was only trying to get the accused inmate moved out of the facility.

IID.110.0011 Investigating Sex Related Offenses and MD Correctional Services Article 10-701 require that allegations of sexual abuse or sexual harassment are referred for investigation to the Internal Investigation Division who has legal authority to conduct criminal investigations. The Agency policy regarding referrals for criminal investigation is located on the agency's website, http://www.dpscs.maryland.gov/prea/index.shtml. The Agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigations.

Through interviews with specialized staff, it was confirned that Internal Investigative Division (IID) conducts the majority of all facility sexual abuse and sexual harassment investigations. If an investigation is determined to be minor in nature, it may be referred back to the facility investigators for investigation. Any investigator who investigates an incident of sexual abuse and/or sexual harassment within a facility is trained in conducting sexual abuse investigations in confinement settings.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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OSPS.050.0030 Sexual Misconduct mandates each employee attend approved training related to preventing, detecting, and responding to acts of sexual misconduct.

Facility Directive UD204 states all facility employees shall be trained to enforce the zero tolerance policy for sexual abuse, harassment, and bullying. All current employees who have not received such training shall be trained within one year of the effective date of the Prison Rape Elimination standards, and the facility shall provide each employee with refresher training every two years to ensure that all employees know the current sexual abuse and sexual harassment policies and procedures. For years in which an employee does not receive refresher training, the facility shall provide refresher information on current sexual abuse and sexual harassment policies. The facility shall document, through employee signature or electronic verification, that employees

understand the training they have received.

The facility provides a variety of training; to include staff training scenarios, PREA In-Service Training, PREA Pre-Service Training, Sexual Harassment Training, and Special Management Offender Training. These lesson plans meet the curriculum standards covered under 115.231(a). The Curriculum Outline and the Lesson Plan for Managing Female Offenders provide gender specific training.

Training is tailored to the gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training. In the past 12 months, 13 staff currently employed by the facility, who may have contact with inmates, have been trained or retrained on the PREA requirements.

Between trainings the agency provides employees who may have contact with residents with information about current policies regarding sexual abuse and sexual harassment. Refresher training is provided during staff meetings on an annual basis.

The agency documents that employees who may have contact with inmates understand the training they have received through employee signature or electronic verification. DPDS.030.0001 Training Requirements states documentation of pre-service training is maintained in the individual employee's training file.

Through a random sample of staff interviews, it was determined the staff were well aware of the Agency's zero tolerance policy and their responsibilities under PREA standards.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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OSPS.050.0030 Sexual Misconduct, Contractor Brochures, and the Volunteer Handbook contain information on sexual misconduct and are readiliy available for contractors, vendors, and volunteers.

Facility Directive UD204 states the facility shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the sexual abuse and sexual harassment prevention, detection, and response policies. The facility shall train all employees and volunteers who may have daily contact with the inmate population. The facility shall document, through contractor and volunteer signatures or electronic verification.

The auditor was advised 11 volunteers and contractors who have contact with inmates, have been trained in agency policies and procedures regarding sexual abuse/harassment prevention, detection, and response.

The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with inmates.

All volunteers and contractors who have contact with inmates have been notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and have been informed on how to report such incidents.

No volunteers were available for interview at the time of the audit; however, one contract employee interview was conducted. The interview indicated contractors and volunteers receive approximately 15-30 minutes of verbal instruction on the Agency's PREA policies and zero tolerance stance towards sexual abuse and sexual harassment. The contractor advised he also received brochures on PREA and was made aware of how he could make a report of sexual abuse, if needed.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information can be found in the Inmate Handbook (2014). Residents also receive information on PREA and sexual assault awareness through posters which are posted in housing units in both English and Spanish.

COS.200.0004 Inmate Sexual Conduct mandates the residents' rights related to resident-on-resident sexual assault are effectively communicated to each resident. DOC.200.0001 Inmate Rights mandates that each warden ensure that newly received residents are provided with information about resident rights, general schedules, procedures, and institutional plans. DPDS.180.0005 Detainee Orientation mandates that residents are trained within seven calender days from intake and a signed acknowledgement of the recipt of training is maintained in the individual's file. DPDS.200.0002 Disability Accommodation mandates that reasonable accomodations are made to provide residents with equal access to programs, services, and activities.

Facility Directive UD203 states during the intake process, residents shall receive information explaining the zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. The Threshold Prison Rape Elimination Program Pamphlet is provided to each resident at intake screening. It describes the key elements of the program and informs residents of the zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents of sexual abuse. It also provides residents notice that male and female staff routinely work and visit resident housing areas. Within seven days of arrival, the Agency shall provide comprehensive education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures.

During the pre-audit, the auditor was provided with a sample of the facility's orientation forms used to educate residents on the facility policies. These orientation forms contained PREA education.

All residents admitted within the past 12 months were given information at intake.

During the past 12 months, there have not been any residents who were transferred from a different community confinement facility.

During the pre-audit, the auditor was provided with a facility PREA Receipt and Acknowledgement that inmates are required to sign at the conclusion of their education session.

During the onsite tour, the auditor discovered PREA posters throughout the facility. The posters contained the reporting telephone number to the Life Crisis Center, which is an outside entity.

During the onsite audit, residents were questioned on their knowledge of PREA and how to report sexual abuse and sexual harassment. One resident replied that while he was waiting to be transferred to Threshold, he watched the PREA video, and upon arrival to Threshold, he watched the video again. Many of the residents acknowledged having watched the video several times.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.200.0004 Inmate Sexual Conduct and DPSCS.050.0030 Sexual Misconduct states that to the extent possible, but in every case where the allegation of alleged resident-on-resident sexual conduct involves sexual abuse, the investigator assigned to investigate the allegation shall have received specialized training related to conducting sexual abuse investigations in a confinement setting that, at minimum, specifically addresses: interviewing sexual abuse victims, Miranda and Garrity Warnings, sexual abuse evidence collection, and criteria and evidence necessary to substantiate administrative action, and if appropriate, criminal prosecution.

A revew of the PREA Lesson Plan for Investigators meets PREA standards. This training is documented by a orientation signature log as well as quizzes given at the conclusion of the training.

All IID staff have completed the specialized training for sexual abuse investigations.

Interviews with investigators confirm they receive specialized training for conducting sexual abuse investigations in confinement settings. The training consisted of the following:

- Techniques for interviewing sexual abuse victims.
- Proper use of Miranda and Garrity warnings.
- Sexual abuse evidence collection in confinement settings.
- The criteria and evidence required to substantiate a case for administrative or prosecution referral.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There are no medical and/or mental health staff who work at Threshold. Residents who require medical and/or mental health care services are treated at Metropolitan Transition Center (MTC).

OSPS.200.0026 PREA Compliance ensures that Department PREA-related activities comply with Federal PREA standards in many areas, including medical and mental health. At the time of the audit, 112 medical and mental health staff who work regularly at MTC have received the training required by Agency policy. This is 85% of the medical and mental health care practitioners who work regularly at MTC. The medical department maintains documentation showing that all medical and mental health care practitioners have completed the required training.

Medical staff interviews indicate medical staff are aware of their responsibility to report and to preserve physical evidence. A review of documentation of the medical training was conducted while onsite and the training covered all required guidelines and protocols.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.200.0005 Screening mandates that residents be screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of intake. Residents are also reassessed within 30 days of the initial assessment. A resident's risk level may also be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness. The policy prohibits staff from disciplining inmates for refusing to answer questions related to whether or not the inmate has a mental, physical, or developmental disability; whether or not the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; whether or not the inmate has previously experienced sexual victimization; and the inmate's own perception of vulnerability.

The assessments are conducted utilizing an objective point based screening instrument. The auditor reviewed a sample of the screenings mentioned above and determined the screenings are being conducted objectively and thoroughly.

During the pre-audit, the auditor was advised the facility started conducting risk screenings approximately 2-3 months ago. The auditor was advised that all the inmates currently residing at the facility have been screened.

During the onsite audit, the auditor requested a sample of risk screenings from the 11 inmates that were randomly choosen to be interviewed. Screenings were conducted on 100% of the residents sampled and were conducted within the required timeframe.

An interview with the Staff Responsible for Risk Screening indicate all residents are screened for risk of sexual victimization and/or being sexually abusive towards other residents. The facility uses an objective screening instrument pursuant to PREA risk assessment requirements. The instrument is a point additive scale used to determine risk vulnerability as well as risk of predatory behavior. This form is also used for reassessments as required to identify a resident's risk of victimization and abusiveness. Residents are not disciplined for refusing to answer questions on this assessment. Additional conversation with staff indicate access to the risk assessments are limited to the risk screening staff and the Director. The intake risk screening staff use the information from the screenings to house those residents who score to be a potential victim in separate housing units from those who score to be a potential predator. The auditor was advised that any resident who scores to be a potential victim or a potential predator would be transferred to a more secure facility.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

COS.200.0005 Screening states that information from the risk screening will be utilized to make decisions related to housing, bed, work, education, and program assignments with the goal of separating those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. The above policy states that the risk screening will be utilized to make individual determinations about how to ensure the safety of each resident. When determining housing and programming assignments for a transgender or intersex inmate, determinations are made on a case-by-case basis.

A review of screenings were conducted while onsite and indicated proper use of the instrument. Staff interviews indicate the standard is being followed.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

OSPS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct establishes procedures for allowing multiple internal ways for residents to report privately to agency officials. Policy states that staff shall accept reports of sexual assault and sexual harassment verbally, in writing, or anonymously. Verbal reports are documented immediately. All reports are classified as confidential and may only be available to individuals who have an established role in the reporting, processing, investigation, and resoloution of the alleged sexual misconduct and immediate and continued care of the victim.

Facility Directive UD221 states reports of sexual abuse and sexual harassment can be made verbally, in writing, anonymously, and from third parties. Residents can submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. There is no time limit to submit a grievance. Inmates are prohibited from engaging in an informal grievance process, or otherwise attempt to resolve with staff, an alleged incident of sexual abuse and sexual harassment. An inmate can submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Grievances alleging sexual abuse shall not be referred to the staff member who is the subject of the complaint. Complaint forms are located in the hallway on the main level of the facility and are not easily viewed by staff. A locked complaint box is located next to the complaint forms on the main level of the facility. The complaint box is checked daily by the Assistant Director, who shall be primarily responsible for ensuring all such complaints and any grievances received are forwarded to the proper managing official. Complaints can be accepted from third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing grievances relating to allegations of sexual abuse and to file such requests on behalf of residents. If a resident declines any third party assistance in filing a grievance alleging sexual abuse, a Matter of Record shall be placed in the resident's House File documenting the resident's decision to decline. A resident may file a complaint with the Inmate Grievance Office under the guidelines of the Office. The Assistant Director shall provide assistance in obtaining the proper forms and for assisting with the preparation of the complaint, if requested. This agency shall cooperate with all investigations of the office and provide any information pertinent to the incident. Rape, sexual assault, sexual harassment, sexual abuse, sexual misconduct, inmate on inmate sexual conduct, or other areas afforded protections by standards established under the authority of the Prison Rape Elimination Act (PREA) and related Department procedures, which shall be addressed according to Department procedures for reporting, investigation, resolving, and documenting PREA related incidents. A resident shall not be subject to disciplinary actions for filing a grievance alleging sexual abuse even when there is evidence that the resident filed the grievance in bad faith.

Information on reporting can be found in the Inmate Handbook (2014) and on the PREA Hotline Posters that are located in the housing units. The PREA Posters contain contact information to an outside entity. The auditor reviewed a PREA Hotline-Life Crisis Center Procedure which outlines a plan of action if a report is made using this service.

Threshold, Inc. does not house inmates detained solely for civil immigration purposes. Staff are required to document verbal reports within 30 minutes of receiving the report.

OSPS.050.0030 Sexual Miscondut outlines the procedures for staff reporting and allows for the complaintant to remain anonymous. Staff are allowed to privately report sexual abuse and sexual harassment of residents utilizing the DPSCS Employee Hotline.

The majority of staff and resident interviews indicated an awareness of avenues to privately report sexual abuse and sexual harassment, and retaliation for reporting. Staff acknowledged an awareness of the staff hotline, while residents were also aware of the PREA hotline specifically for residents.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

OPS.185.0002 Administrative Remedies Procedure states the Department does not permit the use of an informal resolution process or ARP to resolve complaints of rape, sexual assault, sexual harassment, sexual abuse, sexual misconduct, resident-on-resident sexual conduct, or other areas afforded protections by standards established under the authority of the Prison Rape Elimination Act (PREA) and related Department procedures.

Facility Directive UD221 states reports of sexual abuse and sexual harassment can be made verbally, in writing, anonymously, and from third parties. Residents can submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. There is no time limit to submit a grievance. Residents are prohibited from engaging in an informal grievance process, or otherwise attempt to resolve with staff, an alleged incident of sexual abuse and sexual harassment. A resident can submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Grievances alleging sexual abuse shall not be referred to the staff member who is the subject of the complaint. Complaint forms are located in the hallway on the main level of the facility and are not easily viewed by staff. A locked complaint box is located next to the complaint forms on the main level of the facility. The complaint box is checked daily by the Assistant Director, who shall be primarily responsible for ensuring all such complaints and any grievances received are forwarded to the proper managing official. Complaints can be accepted from third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing grievances relating to allegations of sexual abuse and to file such requests on behalf of residents. If a resident declines any third party assistance in filing a grievance alleging sexual abuse, a Matter of Record shall be placed in the resident's House File documenting the resident's decision to decline. A resident may file a complaint with the Inmate Grievance Office under the guidelines of the Office. The Assistant Director shall provide assistance in obtaining the proper forms and for assisting with the preparation of the complaint, if requested. This agency shall cooperate with all investigations of the office and provide any information pertinent to the incident. Rape, sexual assault, sexual harassment, sexual abuse, sexual misconduct, resident-on-resident sexual conduct, or other areas afforded protections by standards established under the authority of the Prison Rape Elimination Act (PREA) and related Department procedures, which shall be addressed according to Department procedures for reporting, investigation, resolving, and documenting PREA related incidents. A resident shall not be subject to disciplinary actions for filing a grievance alleging sexual abuse even when there is evidence that the resident filed the grievance in bad faith.

Agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance.

In the past 12 months, there have not been any grievances filed that alleged sexual abuse.

The agency always notifies residents in writing when the agency files for an extension, including notice of the date by which a decision will be made.

The agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.

Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours.

In the past 12 months, there have not been any emergency grievances alleging substantial risk of imminent sexual abuse.

Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct state the facility shall make reasonably available the services of a victim advocate. When a qualified victim advocate is not available, a Department staff member who is not involved in the incident may serve as the victim advocate.

The Agency has attempted to establish an MOU with Maryland Coalition Against Sexual Assault (MCASA). The auditor was advised that grant funds are available and MCASA has a staff member currently working on a statewide program. The auditor was advised the hospitals also provide a victim advocate for the resident at the hospital. A qualified Agency staff member would serve the role as the victim advocate when needed.

Residents are given mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations.

Enabling reasonable communication between residents and these organizations in as confidential a manner as possible.

The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored.

The facility informs residents, prior to giving them outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

PREA Reporting information can be found in PREA Posters (English and Spanish) located in the housing unit.

During resident interviews, many residents were unfamiliar with services available to resident victims of sexual abuse. This was discussed with the staff during the onsite audit. Prior to the conclusion of the onsite audit, the facility posted the names, mailing addressess, and phone numbers to various victim advocate organizations. The auditor was provided with a photo of this posting, which was posted directly above the resident telephones.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 outlines the Internal Investigative Division's responsibilities for handling third party reports. The auditor verified the Internal Investigative Division's Complaint Number is listed on the agency website along with information about PREA. Reporting information is also listed on PREA Posters and in the Visitor Handbook.

Internal third-party reports can be made utilizing the PREA Hotline and/or the Complaint Box.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030, COS.200.004, and Facility Directive UD211 state that an employee receiving a complaint of, or who otherwise has knowledge of sexual misconduct shall immediately report the information to a supervisor. All reports are classified as confidential and may only be available to individuals who have an established role in the reporting, processing, investigation, and resolution of the alleged sexual misconduct and immediate and continued care of the victim.

The Agency requires all staff to report immediately and according to Agency policy any retaliation against residents or staff who reported such an incident. The Agency requires all staff to report immediately and according to agency policy, any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Numerous staff interviews were conducted and those sampled were knowledgeable and informed of their individual responsibilities in response to sexual abuse.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.200.0004 Inmate Sexual Conduct, OSPS.050.0030 Sexual Misconduct, and COS.200.0005 Screening establishe immediate protection duties for staff.

Over the last 12 months, there have not been any times the facility has determined that a resident was subject to a substantial risk of imminent sexual abuse.

Staff inerviews indicate an understanding of appropriate protective measures (housing reassignments, supervisor notification, and documented reports) would be taken to ensure the safety and security of inmates found to be subject to a substantial risk of imminent sexual abuse.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct state that upon receiving an allegation that a resident was sexually abused while confined at another facility, the allegation will immediately be forwarded to IID. The IID will then determine whether the allegation occurred at a Department facility, and if so, notify the Department official responsible for the facility. If the allegation occurred at a facility that is not a Department facility, the official responsible for the facility will be notified.

Agency policy requires the facility head to provide such notifications as soon as possible, but no later than 72 hours after receiving the allegation.

During the past 12 months, there have not been any allegations the facility received that a resident was abused while confined at another facility.

Agency or facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards.

During the past 12 months, there have not been any allegations of sexual abuse the facility received from other facilities.

During interviews with the management team, the auditor was advised that all allegations of sexual abuse and sexual harassment are investigated regardless of origination.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct state that the first responder safeguard the victim, detain the perpetrator, and take actions so neither the victim nor the perpetrator destroy any physical evidence. All employees, including non-security staff, are required to immediately report any sexual misconduct to a supervisor and request the victim not take actions that could destroy physical evidence.

Facility Directive UD211 states upon learning of an allegation that a resident was sexually abused, the first security staff member to receive the report shall be required to:

1) Preserve and protect any scene of the incident until appropriate steps can be taken to collect any evidence,
2) If the alleged abuse occurred within a time period that still allows for the collection of physical evidence, the resident victim shall be requested to not take any actions that could destroy physical evidence, including, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and,
3) If the abuse occurred within a time period that still allows for the collection of physical evidence, the alleged resident abuser will not be allowed to destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

In the past 12 months, there were not any allegations that a resident was sexually abused.

Interviews with both security and non-security staff indicate an awareness of their duties in response to an allegation of sexual abuse.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct, COS.200.0004 Inmate Sexual Conduct, and the Sexual Assault Notification Tree outline the Agency's coordinated response plan for complaints involving sexual misconduct.

Facility Directive UD209 and UD211 outline specific responsibilities including the transportation of residents for forensic medical examinations.

Management staff indicated the agency has a coordinated response plan in policy and would respond according to the plan in the event of receiving an allegation of sexual abuse.

Standard 115.266 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Facility Directive UD218 states staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. If evidence supports that a staff member engaged in sexual abuse, the matter would first be referred for criminal prosecution. Administrative discipline will be conducted using the Program Statement Standards of Employee Conduct. Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstances of the acts committed. Any contractor or volunteer who engages in sexual abuse shall be barred from the facility and shall be reported to law enforcement agencies and to relevant licensing bodies.

AFSCMETeamstersMOUnitH and MD State Personnel and Pensions 3-302 Management Rights gives sole and exclusive authority for the management of its operations to the Employer.

Interviews at the Agency level confirmed Collective Bargaining Agreements do not restrict the agency's ability to remove staff from the facility during a sexual abuse or sexual harassment investigation.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct, COS.200.0004 Inmate Sexual Conduct, and IID.110.0011 Investigation Sexual Related Offenses state that an individual (staff or inmate) reporting, participating in the investigation or resolution of, or is the victim of sexual misconduct is monitored for 90 days for signs of retaliation. Retaliation may be monitored beyond 90 days when appropriate.

According to directives DPSCS.050.0030.05(B3) and COS.200.0004.05(B3) the responsibility of monitoring for retaliation falls upon the unit head of the resident's housing unit. IID.110.0011.05(H1) places monitoring and follow-up responsibilities on the investigator.

Facility Directive UD218 states inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations shall be free from retaliation by other residents or staff. The Assistant Director shall be designated with monitoring the conduct or treatment of residents and/or staff who reported sexual abuse or sexual harassment. The AD shall also monitor residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible

retaliation by residents or staff. Monitoring shall continue at the discretion of the Executive Director. Disciplinary actions shall be immediately imposed to remedy the instances of retaliation.

There have not been any incidents of retaliation reported in the past 12 months.

Staff interviews indicate an understanding of the Agency's zero tolerance towards retaliation against residents and staff who report sexual abuse and sexual harassment.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

IID.110.0011 Investigating Sex Related Offenses is the Agency policy related to criminal and administrative investigations.

Faclity Directive UD210 states this facility shall ensure that all administrative or criminal investigations are completed for all allegations of sexual abuse and sexual harassment. Residents may be transferred to MRDCC for protective custody while the investigation is ongoing. The facility shall document all such referrals. It is the policy of this facility to coordinate allegations of sexual abuse or sexual harassment with the PREA Compliance Manager and facilitate administrative or criminal investigations as appropriate. This policy shall be published in the resident handbook, the Summary of Services, and in general publications.

Substantiated allegations of conduct that appear to be criminal are referred for prosecution.

There have not been any substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012.

The Agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual assault or sexual harassment for as long as the alleged abuser is incarcerated or employed by the Agency, plus five years.

Interviews with staff confirm IID conducts sexual abuse and sexual harassment investigations. All investigators who conduct these investigations have been properly trained in conducting sexual abuse investigations in confinement settings.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

COMAR.12.02.27.14 Inmate Discipline, COMAR.12.07.01.08 Inmate Grievance, COMAR.12.11.04.09 Office of Secretary, and IID.110.0011 all utilize a preponderance of evidence as its evidentiary standard.

Interviews with investigators confirm investigators' use of preponderance of evidence as its evidentiary standard.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct state the facility shall provide the proper notifications to the resident victim pursuant to 115.73. Notifications will be documented in the resident's base file.

There have not been any criminal and/or administrative investigations of alleged resident sexual abuse completed by the Agency/facility within the last 12 months.

Following a resident's allegation that a staff member has commited sexual abuse against the resident, the Agency/facility subsequently informs the resident (unless the Agency has determined that the allegation is unfounded) whenever: the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the Agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the Agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Following an resident's allegation that he or she has been sexually abused by another inmate in an Agency facility, the Agency subsequently informs the alleged victim whenever; the Agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the Agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

There were not any investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months.

There have not been any founded complaints of sexual abuse committed by a staff member against an inmate in the facility within the past 12 months.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 states that staff are subject to disciplinary action up to and including termination for non-compliance with the requirements contained in this policy. The Standards of Conduct policy categorizes unacceptable behaviors into three categories, according to severity. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Facility Directive UD218 states staff shall be subject to disciplinary sanctions up to and including termination for violating Agency sexual abuse or sexual harassment policies. If evidence supports that a staff member engaged in sexual abuse, the matter would first be referred for criminal prosecution. Administrative discipline will be conducted using the Program Statement Standards of Employee Conduct. Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstances of the acts committed. All terminations for violations of Agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Any contractor or volunteer who engages in sexual abuse shall be barred from the facility and shall be reported to law enforcement agencies and to relevant licensing bodies. The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of Agency sexual abuse or sexual harassment policies by a contractor or volunteer. Inmates shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Termination shall be the presumptive disciplinary sanction for staff who engages in sexual abuse.

In the past 12 months, there have not been any staff from the facility who have violated agency sexual abuse or sexual harassment policies.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DPSCS.050.0030 Sexual Misconduct states that contractors and volunteers who have committed sexual misconduct are subject to criminal prosecution. COMAR.21.07.01.22 Contracts and COMAR.21.01.01.11 require contractors and volunteers to abide by all Federal, State, and local laws or the contract will be terminated.

Facility Directive UD218 states any contractor who engages in sexual abuse and sexual harassment shall be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Any contractor who engages in sexual abuse and sexual harassment shall be prohibited from entering the facility and/or having contact with inmates.

In the past 12 months, no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of inmates.

Contractors are given education on PREA through the facility's PREA Contractor Brochures.

Management team interviews indicate contractors and volunteers are required to adhere to the agency's zero tolerance policy. In

the event a contractor or volunteer violates this policy, they would be removed and banned from the facility.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Residents are subject to formal disciplinary action following an administrative and/or criminal finding that the resident engaged in resident-on-resident coerced sexual abuse and/or non-consensual sexual conduct with staff. This formal process can be found in COMAR.12.02.07 and Facility Directive UD218. DPSCS.050.0030 Sexual Misconduct and COS.200.0004 Inmate Sexual Conduct prohibit disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, eve if an investigation does not establish evidence sufficient to substantiate the allegation.

There have not been any administrative and/or criminal findings of guilt of resident-on-resident sexual abuse.

The Agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

Management staff interviews indicate residents who commit resident-on-resident sexual abuse are transferred to a more secure facility. Disciplinary sanctions would be determined in accordance with DOC disciplinary guidelines.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.200.0004 Inmate Sexual Conduct and DPSCS.050.0030 Sexual Misconduct state that victims will receive immediate access to emergency medical services, when medically appropriate. Prophylactic treatment and testing is offered to the patient, as well as follow-up care for sexually transmitted or other communicable diseases.

Facility Directive UD207 and UD209 outline the medical services provided to resident victims of sexual abuse.

Treatment and services are provided to the victim at no financial cost to the victim.

Security staff and non-security staff interviews indicate medical (including sexually transmitted disease testing) and mental health

services are provided to victims at no cost to the victim.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Medical Evaluation Manual Chapter 13 and Facility Directive UD207 address ongoing medical and mental health care for sexual abuse victims and abusers.

Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

Medical and Mental Health Staff interviews indicate medical and mental health care, including follow-up care are provided to victims of sexual abuse.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.020.0027 PREA Investigations-Tracking and Reviw and DOC.110.0022 Violence Reduction states that the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The facility ordinarily conducts the review within 30 days. The review team consists of upper-level staff to be determined by the Jail Administrator and PREA Compliance Manager and allows input from line supervisors, investigators, and medical or mental health staff. The managing official shall work with the facility's PREA Compliance Manager to implement the review team's recommendations or document the reason for not doing so.

In the past 12 months, there have not been any criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents.

Management staff interviews indicate the incident review team considers whether the incident or allegation was motivated by race; ethinicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang

affiliation; or was motivated or otherwise caused by other group dynamics at the facility; physical barriers, staffing levels, and technology when determining recommendations and improvements.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.020.0027 Tracking PREA Investigations and Facility Directive UD220 outline how the Agency will collect, track, and report allegations of sexual abuse. The Agency utilizes the SSV forms developed by the Department of Justice to collect data. A standard set of definitions is located on these forms.

Through staff interviews it was determined that sexual abuse statistics are tracked by IID. A review of the statistics was conducted at IID. During this time, the auditor confirmed all allegations are tracked. Information retained includes, the date of the incident, incident type, victim information, suspect information, disposition of investigation, and the date the disposition of the investigation was reported back to the resident.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.020.0027 PREA Investigations-Tracking and Review ensures that aggregated sexual abuse data is forwarded to the PREA Coordinator annually, who shall prepare an annual report, which includes an assessment of the Department's sexual abuse prevention, detection, and response policies, practices and training. If applicable, the report will identify Department-wide problem areas or problems within the correctional facility levels.

The annual report compares the current calendar year's data and activites with that available from previous years. The report assesses the Department's progress in addressing sexual abuse. The report is approved by the Secretary and made available to the public through the Department's public website. A review of the Agency website verified the above information, http://www.dpscs.state.md.us/prea/index.shtml.

COS.020.0027 PREA Investigations-Tracking and Review states that specific material may be redacted when it is considered to be information that would present a clear and specific threat to the safety and security of a correctional facility, if publicized. Personal identifiers are also redacted from the report.

Facility Directive UD220 states the Assistant Director shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews. The Agency also shall obtain incident-based and aggregated data from the confinement of inmates. The Agency shall review data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. The Assistant Director shall have input from or access to line supervisors, investigators, and medical or mental health practitioners concerning the incident. The AD shall consider if the incident or allegation indicates a need to change policy or procedure to better prevent, detect, or respond to sexual abuse. The incident or allegation shall be reviewed and considered if it was motivated by race; ethnicity; gender identity; gay, bisexual, transgender, or intersex identification status, or perceived status; gang affiliation; or other group dynamics at this facility. The Assistant Director shall examine the location where the incident allegedly occurred to determine if there are physical plant issues that may have contributed to the incident; and assess staffing levels in the area and the need for monitoring technology to augment or supplement staffing these areas. A detailed report of all findings shall be submitted to the Executive Director and PCM by the Assistant Director. The report shall include,but is not limited to, identifying problem areas; necessary corrective action; and recommendations for improvement. The report shall be made available to the public through emails, website, and distributed upon request. The Agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted. The review will include identifying problem areas, taking corrective action on an ongoing basis; and preparing an annual report of its findings and corrective actions for each facility. Such reports shall include a comparison of the current year's data and corrective actions with those from prior years, if any, and shall provide an assessment of the Agency's progress in addressing sexual abuse. The Agency shall maintain, review, and collect data as needed from all available incident-based docuemnts including reports, investigation files, and sexual abuse incident reviews.

Management staff interviews indicate statistics are tracked at the agency level.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

COS.020.0027 PREA Investigations-Tracking and Review ensures that incident-based and aggregate data are securely retained. This agency policy requires aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its website. This agency policy states before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. This agency policy states the Agency maintains sexual abuse data collected pursuant to 115.87 for at least 10 years from the date received.

A review of the agency website verified the above information, http://dpscs.state.md.us/prea/index/shtml.

Facility Directive UD220 states the Agency shall ensure that data collected are securely retained. The Agency shall make all aggregated sexual abuse data readily available to the public at least annually. Before making aggregated sexual abuse data publicly available, the Agency shall remove all personal identifiers. The facility shall maintain sexual abuse data collection for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise.

During interviews with the PREA Coordinator, it was discovered that sexual abuse and sexual harassment statistics are retained by IID and reviewed by the Secretary and PREA Coordinator anywhere from monthly to quarterly.

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Jeff Kovar — September 24, 2015

Auditor Signature — Date